alzheimer's association®

massachusetts/new hampshire chapter

TUFTS HEALTH PLAN PROJECT

Referral Form

This form is to be used for Tufts Health Plan member referrals to the Dementia Care Consultant. Once complete, please e-mail form to Elyse_Rokos@tufts-health.com

☐ **Commercial** ☐ **USFHP** ☐ **Senior Care Options** ☐ **Tufts Medicare Preferred HMO**

Member Name: _____ Member ID: _____

Type of Dementia: _____ CM Program: _____

Member's Primary Contact: _____ Relationship to Member: _____

Contact Primary Phone: _____ Alternate Phone: _____

PCP: _____ Neurologist/Geriatric Psychiatrist: _____

Referring Case Manager: _____ Phone: _____

HIPAA permission obtained from member? ☐ Yes ☐ No ☐ N/A

Caregiver Assessment Score: _____ ☐ N/A

Needs:

- ☐ Medical issues (dx, medication, etc.)
- ☐ Increase care/support at home
- ☐ Placement/care needs
- ☐ ADLs
- ☐ Symptom management
- ☐ Caregiver support
- ☐ Safety (driving, home alone, safe return etc.)
- ☐ Support groups/education programs
- ☐ Future care planning
- ☐ Early stage issues
- ☐ End of life issues

ADDITIONAL RELEVANT INFORMATION: